Retro Advisory Committee

Minutes taken January 10, 2006
1:00 p.m. at L&I headquarters in Tumwater

The meeting was called to order at 1:05 p.m. by Diane Doherty.

The Retro Advisory Committee members present were: Diane Doherty (chair), Ann Jarvis, Debbie Sullivan, Tammie Hetrick, Mark Shaffer and Linda Harvey.

Introductions

Introductions were made around the room beginning with the committee and then followed by audience members/attendees.

Gary Weeks *(director of the Department of Labor and Industries)* introduced himself and said how much he appreciates the service of the members of the committee. He mentioned that he is very interested in engaging all the advisory groups in this agency in a different way than they have been before. Over the years the Department has offered a lot of reports and data, etc. to its advisory committees, but it doesn't get a lot back. A lot of comments have been made from members who sit on various advisory committees, and they really don't feel like they are advising the Department. They feel like they are receiving information. The Department wants to know what their advice is and use that advice.

Gary also mentioned that he appreciates Diane stepping in to take this leadership role. A permanent person will be found, but in the meantime Diane's service is very much appreciated.

Approval of Minutes

There were no corrections or additions to the October 11th meeting minutes.

ORCA Update

Micki Petty made a presentation on the current status and next phases of the ORCA project.

The first couple pages of the handout is an overview of what has been happening the last few quarters. ORCA Phase 2 was focused mainly on external customers. This is why the new LUCI system was implemented. It is Web based so that images can be accessed.

In June of last year the customer account center was started. This made information available on the Web that is held in the claim files. Payments, time-loss information, and diagnoses are able to now be viewed.

In January 2005 the center was available to external customers who were able to view what was happening with a claim, whether it was open, allowed, the payments, vocational information.

Through December 31st there were quite a few registered customers, including all the retro groups. There are currently over 7,300 people on the claim & account center.

On-line transactions have been started to assist external customers. Since late June of last year, customers have been able to send secure messages. Employers are able to notify the Department if

an employee has returned to work, which automatically suspends a payment. So when an employer informs the Department that an injured worker has returned to work, if there's an ongoing payment in process it automatically suspends the payment and notifies the claims manager.

Also, the injured worker can update their address.

A question from the audience was asked: Is it only the employers that can tell you that the employee can return to work?

Ms. Petty answered that no, the injured worker can, the doctor can and the employer can.

Another concern from the audience was raised that if the employer has the injured worker back, the injured worker is ticked at the employer and doesn't want to come back and the injured worker indicates that they are not back at work, what then.

Ms. Petty answered that if the employer indicates that the employee returned to work or is able to return to work by entering a return-to-work date, that would automatically suspend a payment. If the injured worker does not agree with this, then the claims manager would take further action in regards to contacting the employer, maybe assigning a vocation counselor. But additional information would be needed.

The audience member then asked for clarification that the payment is suspended until the additional information is gathered.

Ms. Petty indicated yes, and if this was disputed by the claimant, the claims manager would have to then make their investigation to resolve the dispute.

There were some examples shown of what the computer screen through claim account center looks like, showing an example of the secure message screen. Examples of the work status screen were also shown.

In October of last year, two new transactions were implemented. Employers are able to fill out the report of accident. Many times, information submitted through the claim account center will show up before the actual report of accident.

Also, the doctors are able to do a medical ability to work. They can certify time-loss on-line.

The LINIIS system is automatically updated for the time-loss payments when a return-to-work date is entered, and the claims manager is informed as soon as the injured worker lets the Department know that their address has changed.

For the month of December, there were over 2,000 secure messages received. The employer, TPA and legal reps made up a large portion of these messages.

An example of what is considered a "multiple relationship" was given as being an attorney but also the employer. So when they log in, they log in as two different roles.

Over 200 work status transactions were received, which enabled the LINIIS system to be updated.

There were over 200 employer reports of accidents, and there were 4 updated medical ability-to-work transactions, which is a 400 percent increase from the prior month.

There was a handout showing that transactions that have been submitted to the Department have steadily increased and shows the different types of transactions that have been received within the Department. The Department will be working on increasing usage for the medical work status transactions; however, they are waiting until the external access is put out there and the system is stable before it is marketed.

Next month there will be new transactions added to the claim & account center. The employer will be able to submit wage information and file protests, and the injured worker can file their work history.

An audience member asked if all parties will be able to file a protest. This was answered affirmatively.

An update was done to the LUCI system, which updated the WISE system, which was not Web based.

In May of 2005 a pilot project was started in which over 50 customers were able to view the actual images. There were attorneys, employer reps, injured workers and physicians that were able to go in and view the images. A couple of different pilot groups were used and then were asked for additional information. Based on this, there are a couple of enhancements that will be implemented next month along with the external access.

The enhancements include the ability for customers to identify confidential documents and the ability for the claims managers to request batch prints of the confidential pages. Now, when the grid screen is viewed, it will say, "medical, confidential" versus nothing at all. A secure message can then be sent to the claims manager requesting the confidential pages. The claims manager can then go and request the batch print of only confidential pages.

A date range for query was added along with the ability to view documents over 50 pages.

The claim imaged documents screen was then shown. This shows the different ways you can query a claim, whether it be the whole claim or just the medical or the third party.

Under "view" if it's a confidential document it will not open. The columns can also be sorted such as by the date received or by the document type.

The Department is also expanding imaging to business internally. It will be expanded to self-insurance, employer services, retrospective rating, provider billing and provider accounts. Provider billing and provider accounts will not have external access.

It was then asked from the audience if there has been a delay in getting information through ORCA because it was moving very slowly and it was rumored that there were server problems. Is the department taking the steps necessary to review that problem?

Ms. Petty answered that yes, today there will be people reviewing what has been happening, every type of error that has come up.

Another question was asked that since the February 9th date is for all customers, is it not a pilot project after that point?

Ms. Petty answered affirmatively.

Tammie Hetrick then asked in regards to the work history, where it says "injured worker only", if there are changes or the employer has additional information, is there going to be somewhere where a response can be added or a modification made?

Ms. Petty indicated no. But the information can be viewed on-line, and if you disagree with it, a secure message can be sent.

Tammie Hetrick then asked when the physicians would be notified about using the system.

Ms. Petty indicated that they were speaking to different medical providers and groups to notify the doctors. At this time it won't be extensively marketed because they want to make sure the system is stable before there are a lot more users.

Actuaries Corner

Nichole Runnels gave two presentations. This first one was a handout that goes over the effects of capping single accidents or occurrences at $500,000. If multiple people are involved in one accident, the total of the cost will not be over $500,000 when it comes to figuring retro refunds.

The handout showed a synopsis as of October 2005. It showed that there were over 50 occurrences in a few of the years shown.

The next page gave an example of claims for participants enrolled in 2001. This is just to give an idea of the costs of the different claims. The one dated 6/10/02 was a multiple-claimant accident and the two amounts were combined. The spreadsheet indicated gross losses ranging from $502,000 to $1,100,000. One of the claims is a time-loss claim for $58,000. There were 32 PPD claims with an average cost of $582,000, 17 TPD claims with an average cost of $643,000, three fatal claims at an average cost of $340,000. Excess losses, those which are not being charged to the employer, range from $2,100 to $602,000.

An example was shown of a multiple-claimant incident. It had 101 claimants, most of them not having an accident-fund amount, 89 having medical only. The average cost for those are $1,800. The gross losses range from $295 to $134,600. There were 8 time-loss claims with an average cost of $16,000 and 4 PPD claims with an average cost of $116,000.

Ann Jarvis then asked if this was just as FYI or was the Department looking at changing and raising the threshold from $500,000 to something else.

Bill Vasek indicated that the Department was going to be looking at that, but they wanted to give some information as to how this system is working today. And the $500,000 cap has not been addressed in probably six years. Currently, it's running about 50 claims per year right now.

Ms. Jarvis then asked if this was considered good, bad or indifferent in an actuarial sense.

Mr. Vasek indicated that that's for the customer to say, whether they feel like they're getting good value out of having a cap. The thing is, if you're not using it, you're still paying for it through reduced refunds. All the cap losses still come into play when the total refund is being calculated. One of the things that capping does is it helps smooth the results. The problem is, if you are a small player, the cap doesn't do any good. $500,000 itself gets you into an additional premium situation. So you have to be pretty large in order for the cap to be of any use. This was not something the Department had planned on addressing today.

Ms. Runnells also noted that the first two pages of her handout included both single occurrences and multiple-claimant occurrences. For example, on Page 2, the $1.1 million dollar claim is one single claim, but the bolded claim for $324,000 is two claims. So in 2001 there was only one multiple-claimant accident that qualified to go over the cap. The rest are single occurrences.

Ms. Runnells then went over the handout showing how the Department calculated the first adjustment PAF for the January 1, 2004, enrollees. The first page shows the calculation difference between the retro and the non-retro losses for the adjustment done in October. The Department uses four quarterly enrollments: Quarter 4 is the most recent, the one that the adjustment is done on. Then information from the previous three quarters are used to come up with the calculations.

Retro and non-retro losses incurred and standard premium is first looked at. The loss ratios are found and the difference is taken between the retro and non-retro loss ratios. That's the basis for looking at the retro refund percentage. The losses have not been developed at this point.

The information is then used to figure out the target refund percentage. A weighted average is calculated of the four quarters to arrive at the 18.74 percent. An interest factor is added, which results in a 19.75 percent target percentage.

To calculate the interest factor, an average of the 10-year treasury bond yield rate for the four quarters is taken. .5 percent is added which is then applied for 13.5 months, which is the average length of time between payment of premium and receipt of refund.

The target refund percentage along with the standard premiums for these four quarters are then used to calculate the target refund, multiplying the standard premium by the target refund percentage.

Then the current-level PAF factors are calculated. The actuarial loss ratios are based on developed losses for the entire state fund, and the relativity is the ratio of loss ratios to the 1/1/04 quarter enrollment loss ratio. This is done so that all four enrollments will be calculated using the same rate level.

The resulting PAF is .9611. The Department then puts in the number that gets the total refund closest to the target refund. .9611 is the rate used. If .9612 was used, the refund would have been $123,004,901, which is less. And if a lower PAF was used, the amount would have been above the target refund.

Bill Vasek then came up and spoke about projects in actuarial services to update the current actuarial tables that are being used. This information was given to the Worker's Comp Advisory Committee in December.

There are four different type of actuarial tables and parameters that are going to be updated. The first is updating the pension annuity tables. These were last updated in 1987. There was a study done based on 1989 through 2004 experience in the pension fund. The pension discount rate was last changed in 1987 as well. So what the Department is going to do is adopt gender-based pension tables into rule.

The next update is going to be looking at the credibility that is used in the experience-rating plan. This is based on a JLARC observation and recommendation. The credibility changes to be made are to reduce the credibility for the larger accounts and increasing the credibility for the smaller accounts. Also, either reduce or omit charges for medical-only claims. This will be done so that the experience-rating plan will be more accurate in predicting future experience of firms. By making these changes, the system will be more accurate.

The next update will be changing the rating-loss development factors methodology by type of claim. This was another JLARC recommendation. This has already been implemented for the 2006 classification rating. So the rates that have been adopted have used this methodology already. The Department is also planning to implement this for retrospective rating. Right now, the Department does look at pension versus non-pension, accident versus medical aid. In addition to this, the Department will be discriminating further upon the type of claim, whether it's a serious claim or a non-serious claim, and if it's a non-serious claim, whether it's a time-loss or PPD.

A serious claim is one which is either a fatal pension -- PPD pension (total permanent disability pension), either a large PPD claim or a large time-loss claim. So it's the more severe claims.

The last update is reviewing and changing the table of insurance charges which underlies the plan tables that are used for retrospective rating. The Department is going to be updating a table that

was produced in 1984 by the National Council of Compensation Insurance. This is a very old table, over 20 years old. The N.C.C.I. has changed their underlying table as well.

The N.C.C.I. was based on experience that was outside of the state of Washington. The Department will be examining the Washington State firm-loss-ratio experience and update the table based on that.

The retrospective rating plans in other states assign hazard groups to each risk classification, which is something that the Department will try to do. Currently, there is a single-loss limitation which Nichole was presenting, the experience of the $500,000 loss limitation. The Department plans to propose several different choices of loss limitations. Some will be larger, some will be smaller. This will help more of the customers in the retro plan because the large $500,000 cap really is only helping the larger retro plan members. So the Department plans to allow choices, giving customers the choice of the smaller loss limitations as well. Also, having a higher loss limitation will result in a smaller charge.

The Department will incorporate all these hazard groups and loss limitations into the tables so that there will be a series of tables instead of just having one table. Once all these tables are obtained, then the plan parameters will be updated based on the new underlying table.

The time frame for these updates was shown. The actuarial studies for the pension tables and the loss-development factor changes have already been done. The studies that still need to be done will be studying the experience-rating plan and also the insurance charges by hazard group. Both these studies have already begun.

Debbie Sullivan then asked if that changes class codes on the hazard groups.

Mr. Vasek indicated that a different hazard group number will be assigned to each classification. The number of hazard groups has not been determined.

Debbie Sullivan then asked if this will be calculated using a multiplier.

Mr. Vasek answered by giving an example: If there were 10 different hazard groups, then every class will have a hazard group number from 1 to 10. So each hazard group will have a different charge. There's two ways this can be done: One, the highest hazard group of all the business groups is taken. But that might not work very well. Another way is to take the different plans and weight them by the premiums by class. But that's going to be an ongoing calculation. The charge will not be known up-front, but it will be known by class. The resulting charge will be based on the mix of business that you then would have. That's probably a better way to implement that. Both of these methods will be proposed.

Another question was asked if the retro groups will take that into the calculation for the retro premium or if it's embedded in the risk class calculation premiums.

Mr. Vasek answered that each hazard group will have its own plan table. There will be a different basic premium charge for Hazard Group 1, a different one for Hazard Group 2. Those will be weighted based on the premiums in each of those two hazard groups. So if half the premium was in Hazard Group 1 and half the premium was in Hazard Group 2, basically an average of those two basic premiums will be used.

Another question was posed from the audience: So it's an insurance charge on top of the claims costs, it's an additional charge?

Mr. Vasek indicated that no, the charge is already in the formula. It will just be a different charge for Hazard Group 1 than for Hazard Group 2. The more hazardous the class is, the higher the insurance charge. Now everybody is in Hazard Group 1 since there's only one hazard group.

The question was asked: "So if I'm understanding, the insurance charge basically now is included in the basic premium ratio of the calculation."

Mr. Vasek confirmed this.

It was then asked: "So what you're doing is you're replacing the basic premium ratio calculation with this new hazard classification charge, incorporating it into it."

Mr. Vasek stated that it's an extra step to calculate it.

The other proposal is you have Hazard Group 1 and Hazard Group 2. You are then classified as Hazard Group 2 because the highest hazard group that you have will be used.

It was then asked, "How does that integrate with the current risk classifications? Let's say you have 10, like you mentioned. Let's say you've got a retro group that's got timber and grocery stores. You've already got a risk classification. Are those being abolished and substituted for the hazard groups or are you just using the hazard group for the use of the insurance charge?"

Mr. Vasek answered that no classes are being abolished. Every class is assigned a hazard number and then the table that corresponds to that class will be used.

Frank Romero then stated, "If you go to the chart Nichole printed out and it's all the claims $500,000 cap, let's say the first 70 percent of those were associated with logging. Logging would probably be the most hazardous. And let's say in Hazard Group 4 you have 10 of the highest ones. And what you're doing is you're measuring the excesses beyond that cap, right? That's where you're coming up with that difference. Your basic premium ratio is a combination of your underwriting, audit, that kind of a charge. It's $500,000 excess."

Mr. Vasek explained that the insurance charge doesn't charge for capping losses at $500,000. What is being looked at is the distribution of loss ratios at the firm level. It's at the aggregate retro entity level.

Mr. Romero then stated, "I thought when you gave an explanation before on basic premium ratio you said the basic premium ratio was made up of three components. One of those components is the excess losses."

Mr. Vasek explained that one of the components is the insurance charge.

Mr. Romero then asked if the insurance charge is the difference between the minimum/maximum premiums that are paid?

Mr. Vasek answered, "No. The insurance charge is the charge for the protection you're getting from premiums going beyond the maximum premium ratio. So if you pick a 1.1 maximum premium ratio, you don't have to pay any more premium than 110 percent of your standard premium. The protection you're getting is incorporated into the insurance charge. And for those classes that are more hazardous, it's more likely that you're going to go beyond 110 percent. Therefore, you should be charged a little bit more. And those that are less hazardous will be charged less." Mr. Vasek also stated that all other states have this incorporated into their retro plan.

Mr. Vasek then went over the effective dates the Department is looking at implementing these changes. The first one, the changing of the pension tables, is expected to be adopted in June of 2005; the experience rating plan changes is expected to be adopted for rates and experience factors starting with the 2007 rating; the retro LDF's, sometime in the middle of 2007; and the insurance charges by hazard group, by the beginning of 2008.

An audience participant asked how the pension tables are going to change.

Mr. Vasek stated that he could send out pension tables to anybody who would like to have them. Basically, the pension tables right now don't differentiate male or female. The plan is to have different male and female tables. There is also a plan to have a different discount rate than the one that is presently being used, which is 6.5 percent.

Tammie Hetrick then asked what discount rate the Department was looking at.

Mr. Vasek stated that a different range of rates were being looked at.

A question from the audience was asked: "I'm wondering if it's clear to everyone what are pension tables used for. They are so that we can determine from each individual claim how much money to set aside to pay that claim, to invest in a pension reserve fund to support that claim. The tables that Bill is talking about is 3 inches of documents that are several look-up tables where you look up a worker's age and then the spouse's age, for example. This would come up with a factor that you multiply times a monthly benefit. It's all part of a pretty complex formula to figure out how much money is actually attributable to any one."

Another participant then asked: "I know that the pension is based on partially what they were making when they were injured. and so that's what it's based on as well?"

An audience member answered that that's one of the factors. In the tables there are things like expected mortality, anticipated interest, marriage potential.

Tammie Hetrick wondered if the Department was looking for input as to whether to use the highest participant or to use averaging. She recommended using averaging.

Mr. Vasek stated that the Department will be taking input on that.

Mr. Vasek also explained that the Department will show what the makeup of each retro association is by hazard group and will give all the retro associations that information.

Ann Jarvis then asked that since it's been 19 years since the pension annuity tables were reviewed and 22 years since the insurance charge has been reviewed, will there be anything put in place that these will be reviewed more quickly, like, maybe every five years or every ten years?

Mr. Vasek stated that every ten years would be a good idea.

Mark Shaffer then asked if an executive summary would be received prior to the implementation of these changes so that the participants could see the impact of these changes before being adopted.

Mr. Vasek explained that this hasn't been discussed in front of the Retro Advisory Committee, but it has been discussed many times before the worker's comp advisory committee. The Department does have a report on the changing of the mortality assumptions. Mr. Vasek then stated he would make sure that everybody on the Retro Advisory Committee would have a copy of that report.

Also, the regular rule-making process will be done on this.

Claims Update

Sandy Dziedzic then gave an update on claims.

There is a concern about the turnover in claims. There have been a lot of changes in the apprenticeship and the assignment of claims where people can keep them longer as they are going through their training and somebody next to them can help them.

All 14 candidates that were hired from the last class could not be put in because there weren't enough vacancies. And it's possible the same thing will happen with the next class.

Last week, 12 people were promoted to WCA 3 Level for the first time since the in-training was stopped several years ago and went to apprentice. These promotional opportunities should help with some of the retention issues. Also, the last of the Level 4 adjudicators were hired and will start in February.

February 9th, on-line imaging will be available as Micki Petty explained earlier. The same claim files will be available to the participants as the claim managers have. Hopefully this will help reduce the use of microfiche. The historical fiche will still be available for older claims.

Medical records have also, in the past, been faxed to TPA's upon request. This will go away since everybody now has the ability to print their own.

Sandy then talked about the changes to gathering wages that starts soon. When the Department received a claim, basic information was obtained right on the accident report, usually from the employer on the employer report of accident, and a payment was made off of that. That's going to happen again. If there's nothing that the claim manager has and they need to get the last date worked, the date returned to work, whether they were kept on salary or there's light duty, phone calls will be made to attempt to obtain this information. But the processing of the claim will not be held up.

The on-line access is now available through the claim & account center for the employer report of accident. The Department has changed their process even if the written portion of the old form is used. Those are imaged as soon as they are received by the Department. This is giving access to the claim information to the claim manager. Through the claim & account center, the ability to update wages or provide wage information will be made available on-line.

Once the employer information is received, the wage order will be issued.

The other change that will be made is if the information is received from the employer that the worker is intermittent or seasonal, rather than calling all the employers and gathering information, the Department will make sure that the worker is paid at the lowest-highest amount. Employment Security will be contacted to find out what their 12-month average is so that the claimant can be paid while the employment history is being gathered. This all starts on Tuesday.

Current high-priority items that are being worked on include the ORCA update and the business process management.

The Department is trying to use the resources more effectively, and that can't be done when five different systems are being used. So the Department is going to try to use a unified desktop which is currently out for bid now.

The Department is working on plans in conjunction with the business process management on how the duration of time-loss claims can be reduced.

Ann Jarvis asked what the current case load is.

Ms. Dziedzic responded that the current case load for the Level 3's is around 230. The Level 2's and apprentices are much higher, around 250 to 260. The Department is going to determine how

many Level 3's and Level 2's are needed so that it can be decided when to promote and plan to hire more apprentices.

SHB1918 Implementation

Vickie Kennedy gave an update on Substitute House Bill 1918.

1918 was a bill passed last year to educate workers on the importance of reporting their injuries to their employers and to educate employers about the importance of getting information to L&I right away. There was a study involved to help the Department understand the impact to workers when there are delays in that reporting process and impact to employers in the form of lost opportunities for return to work.

The Department has requested legislation to move this January into an employer-reporting pilot to start the initiation of claims through employers, which was also an outcome in SHB1918 of the study where statutory recommendations would be made for that change. In the meantime, education efforts are continued that were part of the SHB1918 implementation.

Wallet cards were created for employers to open up conversations with their workers about the importance of informing the employer when they are injured. Those went into production on the Web site on Friday at www.walletcards.lni.wa.gov. From that link, the employer can enter in their UBI number and the cards will be auto filled in and they can be distributed to workers. A newsletter should be going out letting everybody know about the availability of these cards.

One of the other requirements of the bill is that when L&I is aware that the employer has not received a copy of the workers report of accident, then L&I is compelled to send that information on to the employer. Many times, the first notification an employer receives about the claim is when the allowance order is received.

When the doctor's and worker's reports come in through the doctor's office, those are assigned to an employer in a matter of hours. As soon as the employer is assigned to that claim, a letter will be produced to the employer that gives them a legible copy along with a blank form for the employer to fill out.

The letter may need some tweaks. The Department would really appreciate feedback as these are sent out. Any feedback can be sent to Barb Lansford at ritc235@lni.wa.gov.

Another change coming, hopefully by February 1st, is the ability for medical providers to fax reports of accidents. The Department is looking for any way to aid medical providers in speeding up the process and for the Department to minimize any burden to them. It's to everybody's advantage that this information be received quickly. An 800 fax line will be set up for them. This is only for the doctors.

Fraud Update

Carl Hammersburg gave a fraud update. The last time Carl was here he talked about change, introduced a lot of the elements of the fraud bill that had passed in 2004.

There is an annual fraud report that goes to legislature. Unfortunately, they haven't given their full buy-off on it.

The investigation program finished over 3,900 investigations during that first year, up 24 percent from the prior year. The audit program completed over 3,800 audits for the year, up 36 percent from the prior year.

From the investigation standpoint, validity investigations were focused on, hitting that claim right up-front when a concern is expressed, and trying to figure out if the claim is an issue before a lot of money has gone out.

Debbie Sullivan asked if there is a size of a claim that is looked at as a priority.

Mr. Hammersburg stated that priority has been a big concern within the investigations program. So there are time lines that they try to meet on validity investigations which are shorter, within a 30-day period, as opposed to an activity check. In general, it is approached by claims that are received first. When claims managers were asked which ones were high priority, everything was ranked as a high priority.

Some claims are so egregious that the regular methods, regular approaches and civil penalties are not enough. This is the time to put together a criminal case and work with the county prosecutors and see if the individual can be charged or put in prison. There are only a few of these that happen. This has been addressed more in the past year. There were 23 that were referred to county prosecutors last year, up 44 percent from the prior year. This included some employer cases.

One of the issues is that prosecutors are overloaded. So the Department is trying to work with the AG's office to see if there can be money set aside to be able to take on some of the prosecutions.

If there are premiums that are owed, if the Department does not actively seek to collect these funds, then there hasn't been much done to help the industrial insurance fund. So last year the total that was brought in from collections was $105 million, which was up by 12 percent from the prior year. No additional staffing was used to collect this money. Some changes should happen this year, though, that will have an impact there.

The entire fraud prevention compliance program cost $13.6 million for last year to bring in $105 million in collections. There was another $7 million dollars in cost avoidance by taking care of providers that were billing inappropriately, shutting down that ability, shutting down claims that had future payments set out there. What that means is that for ever $1 spent, $8.2 dollars were brought in.

A computer system has been put in place that allows for a single phone unit. It places all the out-going calls, helps to optimize the wait time. A person will manually recall if the computer system is hung-up on. That unit is also engaged on delinquencies a couple weeks quicker than previously.

The Department is looking for fraud-detection software as well as some external auditing and billing review.

The Department started running all claims through a new software a couple months ago to look at fraud detection and many different elements on the claim to help highlight where something different can be done in terms of medical management.

Outreach education is being worked on and hopefully some money can be put towards that this year.

There is a budget package that is in the Governor's budget and will be going to the legislature from the audit program. It is to replace 13-year-old audit software and to get rid of a lot of the manual work that auditors are now doing, particularly at the beginning and end of an audit. It is expected that there will be a return on this investment within a year of its implementation.

Prevention Services

Ernesto Carcamo and Bruce Coulter gave a presentation on a service that they offer.

Bruce Coulter started out the presentation by stating that the best way to manage a claim is to not have one at all. Their efforts are geared towards preventing injuries.

Mr. Coulter then showed a presentation that showed the leading set of injuries and the leading industries in the state that are acquiring injuries of specific kinds. These include falls from elevations, falls at the same level, motor vehicle accidents and musculoskeletal disorders of the lower extremities and musculoskeletal disorders of the neck, back and upper extremities. These injuries accounted for 91.6 percent of all compensable claims, 94.7 percent of compensable claim costs and 95.5 percent of all time-loss days.

Mr. Coulter and Mr. Carcamo work with lower extremity WMSD's and upper extremity MSD's.

Mr. Coulter then showed a short video of a hazardous condition occurring in a sawmill. The cost of a back injury to this particular employee to the employer would have been an increase to their experience factor and their insurance premiums. There also would be additional cost to replacing the worker, training the replacement, managing the claim, possibly a reduction in quality in the work that's being done. To eliminate this particular risk, the cost to the employer ended up being $150. Bottom line: Engineering out hazards of this nature does not have to be expensive.

Mr. Coulter's and Mr. Carcamo's goal is to bring your attention to a resource that's available to retro members, where they can come in and work with you or for you to help get rid of any hazards that exist in the workplace.

Mr. Carcamo then spoke about the Health USA report. in 2004 the two most prevalent diseases that would keep adults from going to work in the USA are back injuries and headaches. In 2004, 4.3 million workers got injured on the job. 1.3 million of those were time-loss accidents or illnesses.

Mr. Carcamo then went on to state that with all the knowledge and technology available, we should not continue to have those striking numbers. Tragedies like the West Virginia mining accident where 12 working men died on their job is not acceptable in the wealthiest nation where technology is available at all levels.

Mr. Coulter then stated that they want to provide these services on the retro community's terms. They can provide very specific training, education on reducing WMSD's by coming to work sites, taking photographs, videotapes of people that work in the business and then apply that in education and training.

Good of the Order

Ms. Doherty then stated that the review and approval of minutes did not get completed. Ann Jarvis moved to approve the minutes, Linda Harvey seconded the motion.

Diana Finch has a survey for everybody to fill out on ideas for the future of the Retro Symposium including timing, format, structure, frequency, topics, any ideas of where the Department should go in the future with the Retro Symposium.

Adjournment

There being nothing else to come before the group, the meeting was adjourned at 3:20 p.m.

Minutes taken/compiled by Cheryl Smith, Court Reporter.